H20 ACTIVITY ENROLLMENT FORM

Participant Name: _____

Birthdate:_____   Gender: M   F

Participant's Address:

_____

Mother's Name: _____ Phone: _____

Mother's Address: _____

Mother's Email: _____ Cell phone: _____

Father's Name: _____ Phone: _____

Father's Address (if different):

_____

Father's Email: _____ Cell phone: _____

Does the participant have a personal caregiver?   Y   N

Will the caregiver be attending program with the participant?   Y   N

Caregiver Name: _____Phone:_____

EMERGENCY CONTACT INFORMATION

1) Name: _____Phone: _____
2) Name: _____Phone: _____
3) Name: _____ Phone: _____

**Please list in order who should be contacted in the event of emergency. Person picking up will be asked to show ID. In case of emergency, EMS should transfer your child to

_____.

I/We authorize staff of H2O at SPUMC to treat an emergency with my child and to call EMS when deemed in my child's best interest.

_____   _____

Name   Date

HEALTH INFORMATION

Diagnosed disability (ies):

_____

Mobility: Uses a wheelchair: Y   N   Uses a walker: Y   N

Food allergies/issues:

_____

_____

Allergies:

_____

_____

Medications:

_____

_____

Will he/she need any meds administered during the program times?   Y   N

If **yes**, please review and sign the "Medication Information Sheet".

Does he/she currently have any of the following conditions?

_____ Seizures   _____ Digestive Issues   _____ Asthma   _____Diabetes

_____ Tube feeding   _____ Oral suctioning   _____ Ostomy bag

If yes, please provide instructions on treatment for those checked:

_____

_____

_____

_____

_____

_____

_____

COMMUNICATION INFORMATION

Please tell us how your child communicates his wants/needs.

_____ Assistive technology device   _____ Verbal

_____ Sounds   _____ Gestures   _____ Eye gaze/movement

Please give details:

_____
_____
_____

If he/she uses an AT device, please send it to the day program but give instructor brief training on usage.

BEHAVIORAL INFORMATION

What kinds of things bring your child pleasure? (i.e. sounds, games, foods, etc.)

_____

What things make your child anxious or upset? (i.e. loud noise, new faces, etc.)

_____

How does your child exhibit pain or being uncomfortable? (i.e. facial gestures, sounds, etc.)

_____

Does he/she display any inappropriate behaviors that may harm him/herself or others?   Y   N   What? _____

Does he/she exhibit ANY of the following behaviors?

_____ Biting   _____ Hitting   ____Screaming   _____Crying

** Please use back of paper if you need more room to provide details.